



Moustafa M.Hassan,M.D.,Director,F.A.C.O.G.
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Patient Name _____
 Age _____ Account Number _____
 Referring Obstetrician _____
 Date Completed _____

Reason(s) for today's appointment _____

Is this pregnancy a result of reproductive technology?(IVF,IUI,donor egg,etc) yes _____ no _____
 Please list pregnancies below in chronological order, beginning with most recent:

YEAR	FULL TERM	LESS THAN 37 WEEKS	MISCARRIAGE	TERMINATED	WEEKS	VAGINAL	C-SECTION	BABY'S WEIGHT	BABY'S SEX	HOURS IN LABOR

GYNECOLOGIC HISTORY

	YES	NO	DATE TREATED	IF YES,EXPLAIN
Abnormal pap smears				
Treatment to cervix (laser,LEEP,biopsy)				
Herpes				
Gonorrhea, Syphilis, Chlamydia				
Condyloma (warts)				
ovarian cysts				
fibroid or fibroid surgery (myomectomy)				
pelvic surgery				

SOCIAL HISTORY

	YES	NO	EXPLAIN
Do you smoke cigarettes?			packs per day__
Do you drink alcohol?			drinks per day__
Do you use street drugs?			list

MEDICAL HISTORY

	YES	NO	DATE DIAGNOSED	MEDICATIONS/TREATMENT/EXPLAIN
Diabetes				
			If Yes,	Doctor's Name/Phone
Hypertension				
			If Yes,	Doctor's Name/Phone
Thyroid Disease				
			If Yes,	Doctor's Name/Phone
Rh Negative Blood				
Blood Transfusion				
Clotting Disorder				
Bleeding Disorder				
Seizure disorder,headaches,migraines				
Asthma				
Heart Disease				
Eating disorder				
Stomach problem,obesity surgery,eating disorder				
Gallstones or Gall Bladder problem				
Liver disease,hepatitis, jaundice				
Kidney disease,stones				
Arthritis,rheumatism,bone or joint problems				
Cancer				

MEDICATIONS (including vitamins and supplements)

MEDICATION NAME	DOSE	# TIMES TAKEN DAILY	DATE STARTED

LIST ALL DRUG ALLERGIES (CHECK HERE IF NONE _____)

MEDICATION NAME	REACTION (ITCHING,NAUSEA,HIVES,SHOCK)	DATE LAST TAKEN

LIST ALL SURGERIES BEGINNING WITH MOST RECENT (CHECK HERE IF NONE _____)

PROCEDURE PERFORMED	YEAR	COMPLICATIONS,IF ANY